“Unknown” may not be used.
None = None
N/A = Not Applicable

Clubhouse of Lehigh County

MEMBERSHIP REFERRAL FORM

Please complete all items. *Do Not Leave Blanks.*

Referring Office/Agency: ____

Person Completing the Referral: ______________________ Phone: ________________

Name of Applicant: _____________________________ Date of Birth: ____________

Address: ____ Apt. # _________

City: ____________________ State: _____ Zip Code: ________ County: ________

Home Phone: ______________________ Cell Phone: ________________________

Social Security Number: ______-______-______ Email: ________________________

Gender:______ Male

______ Female

Race: ______ 1=Black or African American ______ 3=American Indian/Alaskan Native

______ 4=Asian ______ 7=Native Hawaiian or Other Pacific Islander

______ 5=White ______ 6=Other/Not Volunteered by Recipient

Health Insurance Information

MA Access # ___________________ Medical Assistance HMO ___________________

Medicare _____________________ Medicare HMO _________________________

Private Health Insurance Plan ____

For Office Use Only

Admission Date: _______________ County ID #: ________________

Ethnicity: ___________________ Vocational Status: _____________

Living Status: ________________ Population Group: _____________

MENTAL HEALTH TEAM

PROVIDER GROUP	MAIN STAFF/CLINICIAN	PHONE NUMBER	CELL PHONE NUMBER

PRIMARY CARE PROVIDERS

PROVIDER GROUP	MAIN CLINICIAN	ADDRESS	PHONE NUMBER

PLEASE INDICATE ALL THAT APPLY:

_____ Mental Retardation — **If yes, indicate IQ ________** Comment: ________________________________

_____ Learning Disability — Comment: ____

_____ Attention Deficit Disorder (ADD) — Comment: ____

_____ Perceptual Impairment — Comment: ____

_____ Auditory Impairment — Comment: ____

_____ Autism — Comment: ____

_____ Asperger’s Dissorder — Comment: ____

_____ Visual Impairment — Comment: ____

_____ Physical Disabilities — Comment: ____

_____ Seizure Disorder — Comment: ____

_____ Other — Please Specify: ____

_____ Medical Conditions — Please Specify: ____

____

____

____

_____ Allergies —Please Specify: ____

____

REASONS FOR REFERRAL / DESIRED OUTCOMES

For each area of FUNCTION, rate the applicant's current LEVEL using the Key below. Then describe the DESIRED CHANGE the applicant wants to make in each area.

KEY

0 = No Assistance Needed 1 = Needs Mild Assistance
2 = Needs Moderate Assistance 3 = Needs Extensive Assistance

FUNCTION	LEVEL (Number from Key)	DESIRED CHANGE (A Description in Words)
EDUCATION		
SOCIAL		
VOCATIONAL		
SELF MAINTENANCE DAILY LIVING SKILLS		
SELF MAINTENANCE MANAGING ILLNESS & WELLNESS		

EDUCATION HISTORY

TYPE OF EDUCATION	NAME OF SCHOOL	HIGHEST GRADE	DATES	DIPLOMA/MAJOR
HIGH SCHOOL/GED				
TRADE OR TECH				
COLLEGE				
OTHER				

Is the applicant involved in any educational/training programs at the present time: _____Yes _____No
If yes, please describe the program: ____

____

Does the applicant have an interest in further education: _____Yes _____No
If yes, please describe what kind of education: ____

____

THIS PORTION OF THE REFERRAL FORM MUST BE COMPLETED BY A PSYCHIATRIST OR THERAPIST

Name of Clubhouse Applicant ______________________________
Name of Psychiatrist/Therapist ______________________________
Address ______________________________
____
Phone ______________________________

BEHAVIORAL HEALTCH CARE INFORMATION

Psychiatric Diagnosis (DSM # must be included.)
Axis I________________________ DSM # _____
Axis II_______________________ DSM #_____
Axis III______________________________
Axis IV ______________________________
Axis V_______________________________

Current D & A Use
Type? ______________________________
Frequency? __________________________
Current D & A Treatment
____
Attend 12-Step Meetings? _____Yes _____No
Frequency? __________________________

PSYCHIATRIC MEDICATIONS

Describe any presence of significant harm to self, others or property, or any unusual behaviors.
Give dates and details:____
____
____

Describe any incidents of violence, arrests, prison terms, fire setting.
Give dates and details:____
____
____

Describe any current legal involvement (DUI, custody, probation, parole, etc.
Give dates and details:____
____
____

Parole/Probation Officer: Name_________________________________ Phone______________

Signature of Psychiatrist/Therapist ______________________________Date______________

Is the applicant currently working? _____ Yes _____ No
If yes, what is the job title?____________________________
If yes, give company name ____________________________
If yes, give the days and hours worked each week ______________________________

Describe any previous work experience the applicant has. _______________________________________
____

Does the applicant have any volunteer experience? _____ Yes _____ No
If yes, where did the applicant volunteer? ____
If yes, what kind of volunteer work was it? ____

List the applicant's hobbies, talents or special interests. ____
____
____

What would the applicant like to accomplish by coming to Clubhouse?_____________________________
____
____
____
____
____
____
____

Notice to Clubhouse Applicant: *All member information is confidential. Staff/members are responsible for new member processing and orientation.*

To schedule orientation, Clubhouse should contact:
_____ Applicant Phone #_________________________
_____ Other Name _________________________ Phone # _________________________

Applicant's Signature ________________________________ Date _________________

Please forward the completed referral form to:

Clubhouse of Lehigh County
1437 Gordon Street
Allentown, PA 18102
Attn: Director

Phone: 610-433-9910
Fax: 610-433-9940